SEER Site-Specific Coding Guidelines
BREAST
C500–C509

Primary Site

C500 **Nipple** (areolar)
Paget disease without underlying tumor

C501 **Central** portion of **breast (subareolar)** area extending 1 cm around areolar complex
Retroareolar
Infraareolar
Next to areola, NOS
Behind, beneath, under, underneath, next to, above, cephalad to, or below nipple
Paget disease with underlying tumor

C502 **Upper inner quadrant** (UIQ) of breast
Superior medial
Upper medial
Superior inner

C503 **Lower inner quadrant** (LIQ) of breast
Inferior medial
Lower medial
Inferior inner

C504 **Upper outer quadrant** (UOQ) of breast
Superior lateral
Superior outer
Upper lateral

C505 **Lower outer quadrant** (LOQ) of breast
Inferior lateral
Inferior outer
Lower lateral

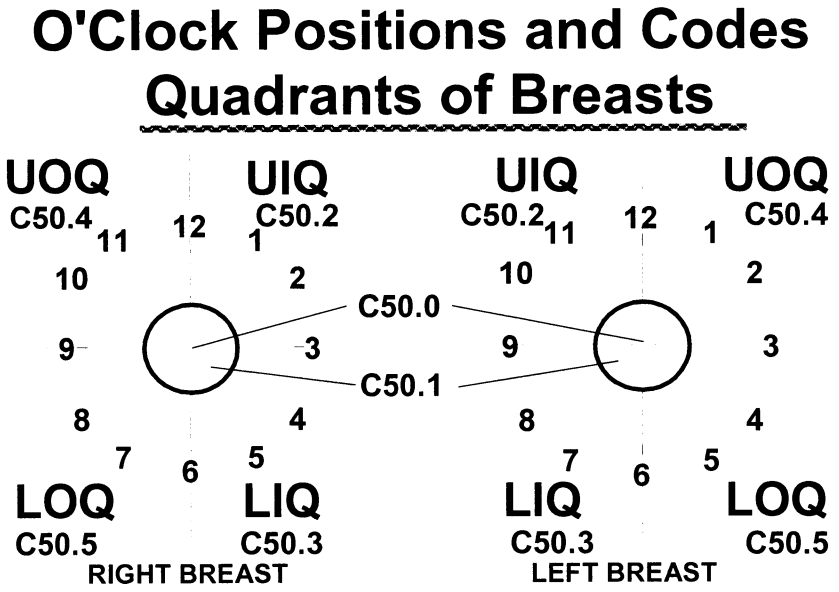
C506 **Axillary tail** of breast
Tail of breast, NOS
Tail of Spence

C508 **Overlapping** lesion of breast
Inferior breast, NOS
Inner breast, NOS
Lateral breast, NOS
Lower breast, NOS
Medial breast, NOS
Midline breast NOS
Outer breast NOS
Superior breast, NOS
Upper breast, NOS
3:00, 6:00, 9:00, 12:00 o'clock

C509 Breast, NOS
Entire breast
Multiple tumors in different subsites within breast
Inflammatory without palpable mass
¾ or more of breast involved with tumor
Diffuse (tumor size 998)

Additional Subsite Descriptors

The position of the tumor in the breast may be described as the positions on a clock



Priority Order for Coding Subsites

Use the information from reports in the following priority order to code a subsite when the medical record contains conflicting information:

1 Pathology report
2 Operative report
3 Physical examination
4 Mammogram, ultrasound

If the pathology proves invasive tumor in one subsite and in situ tumor in all other involved subsites, code to the subsite involved with invasive tumor

When to Use Subsites 8 and 9

A. Code the primary site to C50**8** when there is a single tumor that overlaps two or more subsites, and the subsite in which the tumor originated cannot be determined.
B. Code the primary site to C50**8** when there is a **single tumor** located at the **12, 3, 6, or 9 o'clock** position on the breast
C. Code the primary site to C509 when there are multiple tumors (two or more) in at least two quadrants of the breast.

Determining Multiple Primaries and Histology for Breast

Refer to the site-specific rules for breast in Appendix O, MP/H rules to determine the number of primaries and the correct histology.

Note: *For cases diagnosed prior to 2007 refer to the CRH, Revised 2007.*

Grade

Priority Rules for Grading Breast Cancer

Code the tumor grade using the following priority order:

Bloom-Richardson (Nottingham) scores 3-9 converted to grade (see conversion table on page 372)
Bloom Richardson grade (low, intermediate, high)
Nuclear grade only
Terminology
Differentiation (well differentiated, moderately differentiated, etc)
Histologic grade
Grade i, grade ii, grade iii, grade iv

Bloom-Richardson (BR)

BR may also be called: modified Bloom-Richardson, Scarff-Bloom-Richardson, SBR grading, BR grading, Elston-Ellis modification of Bloom Richardson score, the Nottingham modification of Bloom Richardson score, Nottingham-Tenovus, or Nottingham grade.

BR may be expressed in scores (range 3-9)
The score is based on three morphologic features of "invasive no-special-type" breast cancers (degree of tubule formation/histologic grade, mitotic activity, nuclear pleomorphism of tumor cells).

BR may be expressed as a **grade** (low, intermediate, high). BR grade is derived from the BR score.

Use the table below to convert Bloom-Richardson (Nottingham) Scores; Bloom-Richardson Grade; Nuclear Grade; Terminology; and Histologic Grade to the appropriate code. (Note that the conversion of low, intermediate, and high is different from the conversion used for all other tumors)

Bloom-Richardson (Nottingham) Combined Scores	Bloom-Richardson Grade	Nuclear Grade	Terminology	Histologic Grade	Code
3 - 5 points	Low grade	1/3, 1/2	Well differentiated	I/III or 1/3	1
6, 7 points	Intermediate grade	2/3	Moderately differentiated	II/III or 2/3	2
8, 9 points	High grade	2/2, 3/3	Poorly differentiated	III/III or 3/3	3

Laterality

Laterality must be coded for all subsites.

Size of Primary Tumor Coding Guidelines

Purely Invasive or Purely Insitu: Priority in which to use Reports to Code Tumor Size

1. Pathology report
2. Operative report
3. Physical examination
4. Imaging (mammography)
5. Imaging (ultrasound)

Both Invasive and Insitu Components

Single Tumor: Record the size of the invasive component
Multiple Tumors: Record the size of the largest invasive tumor

Additional rules for coding breast primaries size:

If the size of the invasive component is ***not*** given, record the size of the entire tumor from the surgical report, pathology report, radiology report or clinical examination.

The descriptions in code 998 take precedence over any mention of size.
Breast (C50.0–C50.6, C50.8–C50.9): Diffuse, Code 998

Neoadjuvant Treatment
Code the largest tumor size documented, clinical or pathologic, if neoadjuvant treatment is given.

CODING REGIONAL LYMPH NODES FOR BREAST

Coding regional lymph node involvement for breast cancers is more complex than for many other sites, especially when dealing with isolated tumor cells (ITCs) and micrometastases. The following may help clarify the reasons behind the codes in CS Lymph Nodes.

Isolated Tumor Cells (ITCs). Pathologists can detect isolated tumor cells (ITCs) spread from a breast cancer into regional lymph nodes. These are very small deposits of tumor cells, so small that they are ***not*** considered significant for assigning stage. They usually do not show evidence of malignant activity in the nodes, such as proliferation or stromal reaction. To be considered ITCs, they must be single tumor cells or small clusters not more than 0.2 mm. As more data are collected about these ITCs, their prognostic significance may be better understood. **At this time, nodes with only these ITCs are NOT considered positive nodes. The CS Lymph Nodes code would be 05 if detected by H and E stains, but the CS Reg LN Pos code would be 00.** These ITCs are most often found using immunohistochemistry tests on sentinel lymph node specimens. If **ITCs** are found by **IHC or molecular methods** the **CS Lymph Nodes code would by 00** and the CS Reg LN Pos code would be 00.

Hematoxylin and Eosin (H & E). (from AHematoxylin & Eosin@: (The Routine Stain)), by H. Skip Brown, BA, HT (ASCP), : http://www.sigmaaldrich.com/img/assets/7361/Primer-H&Emay04.pdf In histology, the standard or routine stain is the hematoxylin and eosin stain, better known as the "H&E" stain. With rare exceptions, every specimen being examined will first receive an H&E stain to give the laboratorian a visible look at the nucleus of the cells and their present state of activity. With most disease states there is abnormal growth and/or division in the nucleus of the cells. The hematoxylin and eosin stain uses two separate dyes, one staining the nucleus and the other staining the cytoplasm and connective tissue. Hematoxylin is a dark purplish dye that will stain the chromatin (nuclear material) within the nucleus, leaving it a deep purplish-blue color. Eosin is an orangish-pink to red dye that stains the cytoplasmic material including connective tissue and collagen, and leaves an orange-pink counterstain. This counterstain acts as a sharp contrast to the purplish-blue nuclear stain of the nucleus, and helps identify other entities in the

tissues such as cell membrane (border), red blood cells, and fluid.

Immunohistochemistry (IHC). Immunohistochemistry (IHC) tests use antibodies to stain for proteins of interest in tissue specimens. The IHC test for metastatic breast cancer in lymph nodes uses antibodies to cytokeratin, so the test may be called Acytokeratin staining.@ Other IHC tests are used on the primary breast tumor, rather than the lymph nodes, to assess estrogen and progesterone receptors and HER-2 neu (human epidermal growth factor receptor).

Molecular Study: Reverse Transcriptase/Polymerase Chain Reaction (RT-PCR). An even more sensitive test used to detect ITCs in lymph nodes is RT-PCR, a molecular test looking for expression of genes of interest. This test is rarely done.

Micrometastasis. When the tumor deposits in the lymph nodes are larger than 0.2 mm but not larger than 2.0 mm, they are defined as micrometastasis. **Nodes with micrometastasis ARE considered positive for staging.**

Collaborative Staging Codes
Breast
C50.0-C50.6, C50.8-C50.9
C50.0 Nipple
C50.1 Central portion of breast
C50.2 Upper-inner quadrant of breast
C50.3 Lower-inner quadrant of breast
C50.4 Upper-outer quadrant of breast
C50.5 Lower-outer quadrant of breast
C50.6 Axillary Tail of breast
C50.8 Overlapping lesion of breast
C50.9 Breast, NOS
Note: Laterality must be coded for this site

Breast
CS Tumor Size (Revised: 07/28/2006)
Note 1: For tumor size, some breast cancers cannot be sized pathologically.
Note 2: When coding pathologic size, code the measurement of the invasive component. For example, if there is a large in situ component (e.g., 4 cm) and a small invasive component see Site-Specific Factor 6 to code more information about the reported tumor size. If the size of invasive component is not given, code the size of the entire tumor and record what it represents in Site-Specific Factor 6.
Note 3: Microinvasion is the extension of cancer cells beyond the basement membrane into the adjacent tissues with no focus more than 0.1 cm in greatest dimension. When there are multiple foci of microinvasion, the size of only the largest focus is used to classify the microinvasion. (Do not use the sum of all the individual foci.)

Code	Description
000	No mass/tumor found
001-988	001 - 988 millimeters (code exact size in millimeters)
989	989 millimeters or larger
990	Microinvasion; microscopic focus or foci only, no size given; described as less than 1 mm
991	Described as "less than 1 cm"
992	Described as "less than 2 cm," or "greater than 1 cm," or "between 1 cm and 2 cm"
993	Described as "less than 3 cm," or "greater than 2 cm," or "between 2 cm and 3 cm"
994	Described as "less than 4 cm," or "greater than 3 cm," or "between 3 cm and 4 cm"
995	Described as "less than 5 cm," or "greater than 4 cm," or "between 4 cm and 5 cm"
996	Mammographic/xerographic diagnosis only, no size given; clinically not palpable

997	Paget's Disease of nipple with no demonstrable tumor
998	Diffuse
999	Unknown; size not stated Not documented in patient record

Breast

CS Extension (Revised: 08/15/2006)

Note 1: Changes such as dimpling of the skin, tethering, and nipple retraction are caused by tension on Cooper's ligament(s), not by actual skin involvement. They do not alter the classification.

Note 2: Consider adherence, attachment, fixation, induration, and thickening as clinical evidence of extension to skin or subcutaneous tissue, code '20'.

Note 3: Consider "fixation, NOS" as involvement of pectoralis muscle, code '30'.

Note 4: If extension code is 00, then Behavior code must be 2; if extension code is 05 or 07, then behavior code may be 2 or 3; and, if extension code is 10, then behavior code must be 3.

Note 5: Inflammatory Carcinoma. AJCC includes the following text in the 6th edition Staging Manual (p. 225-6), "Inflammatory carcinoma is a clinicopathologic entity characterized by diffuse erythema and edema (peau d'orange) of the breast, often without an underlying palpable mass. These clinical findings should involve the majority of the skin of the breast. Classically, the skin changes arise quickly in the affected breast. Thus the term of inflammatory carcinoma should not be applied to a patient with neglected locally advanced cancer of the breast presenting late in the course of her disease. On imaging, there may be a detectable mass and characteristic thickening of the skin over the breast. This clinical presentation is due to tumor emboli within dermal lymphatics, which may or may not be apparent on skin biopsy. The tumor of inflammatory carcinoma is classified T4d. It is important to remember that inflammatory carcinoma is primarily a clinical diagnosis. Involvement of the dermal lymphatics alone does not indicate inflammatory carcinoma in the absence of clinical findings. In addition to the clinical picture, however, a biopsy is still necessary to demonstrate cancer either within the dermal lymphatics or in the breast parenchyma itself."

Note 6: For Collaborative Staging, the abstractor should record a stated diagnosis of inflammatory carcinoma, and also record any clinical statement of the character and extent of skin involvement in the text area. Code 71 should be used if there is a stated diagnosis of inflammatory carcinoma and a clinical description of the skin involvement in less than 50% of the skin of the breast. Code 73 should be used if there is a stated diagnosis of inflammatory carcinoma and a clinical description of the skin involvement in more than 50% (majority) of the skin of the breast. Cases with a stated diagnosis of inflammatory carcinoma but no such clinical description should be coded 71. A clinical description of inflammation, erythema, edema, peau d'orange, etc. without a stated diagnosis of inflammatory carcinoma should be coded 51 or 52, depending on described extent of the condition.

Code	Description	TNM	SS77	SS2000
00	In situ: noninfiltrating; intraepithelial Intraductal WITHOUT infiltration Lobular neoplasia	Tis	IS	IS
05	Paget Disease of nipple (WITHOUT underlying tumor)	Tis	**	**

07	Paget Disease of nipple (WITHOUT underlying invasive carcinoma pathologically)	Tis	**	**
10	Confined to breast tissue and fat including nipple and/or areola Localized, NOS	*	L	L
20	Invasion of subcutaneous tissue Local infiltration of dermal lymphatics adjacent to primary tumor involving skin by direct extension Skin infiltration of primary breast including skin of nipple and/or areola	*	RE	RE
30	Attached or fixation to pectoral muscle(s) or underlying tissue Deep fixation Invasion of (or fixation to) pectoral fascia or muscle	*	RE	RE
40	Invasion of (or fixation to): Chest wall Intercostal or serratus anterior muscle(s) Rib(s)	T4a	RE	RE
51	Extensive skin involvement, including: Satellite nodule(s) in skin of primary breast Ulceration of skin of breast Any of the following conditions described as involving not more than 50% of the breast, or amount or percent of involvement not stated: Edema of skin En cuirasse Erythema Inflammation of skin Peau d'orange ("pigskin")	T4b	RE	RE
52	Any of the following conditions described as involving more than 50% of the breast WITHOUT a stated diagnosis of inflammatory carcinoma: Edema of skin En cuirasse Erythema Inflammation of skin Peau d'orange ("pigskin")	T4b	RE	RE
61	(40) + (51)	T4c	RE	RE
62	(40) + (52)	T4b	RE	RE

71	Diagnosis of inflammatory carcinoma WITH a clinical description of inflammation, erythema, edema, peau d'organge, etc., involving not more than 50% of the skin of the breast, or percent of involvement not stated, WITH or WITHOUT dermal lymphatic infiltration. Inflammatory carcinoma, NOS	T4b	RE	RE
72	OBSOLETE – Description: Diagnosis of inflammatory WITH a clinical diagnosis of inflammation, erythema, edema, peau d'orange, etc., of more than 50% of the breast, WITH or WITHOUT dermal lymphatic infiltration Inflammatory carcinoma, NOS NOTE: Code 72 has been combined with code 71. Any cases coded to 72 should be re-coded to 71.	T4b	RE	RE
73	Diagnosis of inflammatory carcinoma WITH a clinical description of inflammation, erythema, edema, peau d'orange, etc., of more than 50% of the skin of the breast, WITH or WITHOUT dermal lymphatic infiltration	T4d	RE	RE
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

Breast
CS TS/Ext-Eval
SEE STANDARD TABLE

Breast

CS Lymph Nodes (Revised: 10/03/2007)

Note 1: Code only regional nodes and nodes, NOS, in this field. Distant nodes are coded in the field Mets at DX.

Note 2: If the pathology report indicates that nodes are positive but size of the metastases is not stated, assume the metastases are greater than 0.2 mm and code the lymph nodes as positive in this field. Use code 60 in the absence of other information about regional nodes.

Note 3: If no lymph nodes were removed for evaluation (Reg Nodes Eval code 0, 1, or 9), or if neoadjuvant therapy was given and clinical lymph node involvement is AS extensive or MORE extensive than pathologic lymph node involvement (Reg Nodes Eval code 5), then use only the following codes for clinical evaluation of regional nodes: 0, 29, 51, 60, 74, 75, 76, 77, 78, 80, and 99. Do not use codes 29 and 51 under any other circumstances (Reg Nodes Eval 2, 3, 6, or 8).

Note 4: Isolated tumor cells (ITC) are defined as single tumor cells or small clusters not greater than 0.2 mm, usually detected only by immunohistochemical (IHC) or molecular methods but which may be verified on H and E stains. ITCs do not usually show evidence of malignant activity (e.g. proliferation or stromal reaction). Lymph nodes with ITCs only are not considered positive lymph nodes.

Note 5: Codes 13-52 are used for positive axillary nodes without internal mammary nodes.

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement, or ITCs detected by immunohistochemistry or molecular methods ONLY. (See Note 5 and Site-specific Factors 4 and 5.)	*	NONE	NONE
05	None: no regional lymph nodes(s) but with (ITC's) detected on routing H and E stains. (See Note 5)	N0(i+)	NONE	NONE
13	Axillary lymph node(s), ipsilateral, micrometastasis ONLY detected by immunohistochemical (IHC) means ONLY (at least one micrometastasis greater than 0.2 mm and all micrometastases less than or equal to 2 mm)	N1mi	RN	RN
15	Axillary lymph node(s), ipsilateral, micrometastasis ONLY detected or verified on H&E (at least one micrometastasis greater than 0.2 mm and all micrometastases less than or equal to 2 mm) Micrometastasis, NOS	N1mi	RN	RN
25	Movable axillary lymph node(s), ipsilateral, positive with more than micrometastasis (i.e., at least one metastasis greater than 2 mm)	**	RN	RN
26	Stated as N1, NOS	**	RN	RN
28	OBSOLETE - Stated as N2, NOS	**	RN	RN
29	Clinically stated only as N2, NOS (clinical assessment because of neoadjuvant therapy or no pathology)	**	RN	RN

30	Pathologically stated only as N2, NOS; no information on which nodes were involved	**	RN	RN
50	OBSOLETE - Fixed/matted ipsilateral axillary nodes, positive with more than micrometastasis (i.e., at least one metastasis greater than 2 mm) Fixed/matted ipsilateral axillary nodes, NOS	**	RN	RN
51	Fixed/matted ipsilateral axillary nodes clinically (clinical assessment because of neoadjuvant therapy or no pathology) Stated clinically as N2a, NOS (clinical assessment because of neoadjuvant therapy or no pathology)	**	RN	RN
52	Fixed/matted ipsilateral axillary nodes clinically with pathologic involvement of lymph nodes at least one metastasis greater than 2mm.	**	RN	RN
60	Axillary/regional lymph node(s), NOS Lymph nodes NOS	**	RN	RN
71	Internal mammary node(s), ipsilateral, positive on sentinel nodes but not clinically apparent (no positive imaging or clinical exam) WITHOUT axillary lymph node(s), ipsilateral	N1b	RN	RN
72	Internal mammary node(s), ipsilateral, positive on sentinel nodes but not clinically apparent (no positive imaging or clinical exam) WITH axillary lymph node(s), ipsilateral	**	RN	RN
73	Internal mammary node(s), ipsilateral, positive on sentinel nodes but not clinically apparent (no positive imaging or clinical exam) UNKNOWN if positive axillary lymph node(s), ipsilateral	N1b	RN	RN
74	Internal mammary node(s), ipsilateral, clinically apparent (on imaging or clinical exam) WITHOUT axillary lymph node(s), ipsilateral	N2b	RN	RN
75	Infraclavicular lymph node(s) (subclavicular)	N3a	D	RN
76	Internal mammary node(s), ipsilateral, clinically apparent (on imaging or clinical exam) WITH axillary lymph node(s), ipsilateral, codes 15 to 60 WITH or WITHOUT infraclavicular lymph node(s)	N3b	RN	RN
77	Internal mammary node(s), ipsilateral, clinically apparent (on imaging or clinical exam) UNKNOWN if positive axillary lymph node(s), ipsilateral	N2b	RN	RN

78	(75) + (77)	N3a	D	RN
79	Stated as N3, NOS	N3NOS	RN	RN
80	Supraclavicular node(s)	N3c	D	D
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

Breast
Reg LN Pos (Revised: 08/21/2006)
Note 1: Record this field even if there has been preoperative treatment.
Note 2: Lymph nodes with only isolated tumor cells (ITCs) are NOT counted as positive lymph nodes. Only lymph nodes with metastases greater than 0.2mm (micrometastases or larger) should be counted as positive. If the pathology report indicates that nodes are positive but size of the metastases is not stated, assume the metastases are > 0.2mm and code the lymph nodes as positive in this field.
Note 3: Record all positive regional lymph nodes in this field. Record the number of positive regional axillary nodes separately in the appropriate Site-Specific Factor field.

Code	Description
00	All nodes examined negative.
01-89	1 - 89 nodes positive (code exact number of nodes positive)
90	90 or more nodes positive
95	Positive aspiration or core biopsy of lymph node(s)
97	Positive nodes - number unspecified
98	No nodes examined
99	Unknown if nodes are positive; not applicable Not documented in patient record

Breast
Reg LN Exam
SEE STANDARD TABLE

Breast
CS Mets at DX (Revised: 05/06/2004)
Note: Supraclavicular (transverse cervical) is moved to CS Lymph Nodes.

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE
10	Distant lymph node(s) Cervical, NOS	M1	D	D

10 cont'd	Contralateral/bilateral axillary and/or internal mammary Other than above Distant lymph node(s), NOS	M1	D	D
40	Distant metastases except distant lymph node(s) (code 10) Distant metastasis, NOS Carcinomatosis	M1	D	D
42	Further contiguous extension: Skin over: Axilla Contralateral (opposite) breast Sternum Upper abdomen	M1	D	D
44	Metastasis: Adrenal (suprarenal) gland Bone, other than adjacent rib Contralateral (opposite) breast - if stated as metastatic Lung Ovary Satellite nodule(s) in skin other than primary breast	M1	D	D
50	(10) + any of [(40) to (44)] Distant lymph node(s) plus other distant metastases	M1	D	D
99	Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record	MX	U	U

Site Specific Surgery Codes
Breast
C500–C509
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

00 None; no surgery of primary site; autopsy ONLY

19 Local tumor destruction, NOS
No specimen was sent to pathology for surgical events coded 19 (principally for cases diagnosed prior to January 1, 2003)

20 Partial mastectomy, NOS; less than total mastectomy, NOS
- 21 Partial mastectomy WITH nipple resection
- 22 Lumpectomy or excisional biopsy
- 23 Reexcision of the biopsy site for gross or microscopic residual disease
- 24 Segmental mastectomy (including wedge resection, quadrantectomy, tylectomy)

Procedures coded 20–24 remove the gross primary tumor and some of the breast tissue (breast-conserving or preserving). There may be microscopic residual tumor.

Note: **A lumpectomy with lymph node dissection would be coded to 22 rather than 50.**

30 Subcutaneous mastectomy
A subcutaneous mastectomy is the removal of breast tissue without the nipple and areolar complex or overlying skin
[**SEER Note:** This procedure is rarely used to treat malignancies]

40 Total (simple) mastectomy, NOS
- 41 WITHOUT removal of uninvolved contralateral breast
- 43 Reconstruction, NOS
  - 44 Tissue
  - 45 Implant
  - 46 Combined (Tissue and implant)
- 42 WITH removal of uninvolved contralateral breast
- 47 Reconstruction, NOS
  - 48 Tissue
  - 49 Implant
  - 75 Combined (Tissue and implant)

[**SEER Notes:** If axillary lymph nodes are present in the specimen, code the Surgery of Primary Site field to 51. If there are no axillary lymph nodes present in the specimen, code the Surgery of Primary Site field to 41. Placement of a tissue expander at the time of original surgery means that reconstruction is planned as part of the first course of treatment.]

A total (simple) mastectomy removes all breast tissue, the nipple, and areolar complex. An axillarydissection is not done.

For **single** primaries only, code removal of involved contralateral breast under the data item **Surgical Procedure/Other Site** (NAACCR Item # 1294)

If **contralateral breast** reveals a **second primary**, *each breast is abstracted separately.* The surgical procedure is coded 41 for the first primary. The surgical code for the contralateral breast is coded to the procedure performed on that site.

50 Modified radical mastectomy
- 51 WITHOUT removal of uninvolved contralateral breast
- 53 Reconstruction, NOS
  - 54 Tissue
  - 55 Implant
  - 56 Combined (Tissue and Implant)
- 52 WITH removal of uninvolved contralateral breast
- 57 Reconstruction, NOS
- 58 Tissue
- 59 Implant
- 63 Combined (Tissue and Implant)

Removal of all breast tissue, the nipple, the areolar complex, and variable amounts of breast skin in continuity with the axilla. The specimen may or may not include a portion of the pectoralis major muscle.

If **contralateral breast** reveals a **second primary**, *each beast is abstracted separately.* The surgical procedure is coded 51 for the first primary. The surgical code for the contralateral breast is coded to the procedure performed on that site.

For **single primaries** only, code removal of involved contralateral breast under the data item **Surgical Procedure/Other Site** (NAACCR Item # 1294)

[**SEER Notes**: In continuity with or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen. "Tissue" for reconstruction is defined as human tissue such as muscle (latissimus dorsi or rectus abdominis) or skin in contrast to artificial prostheses (implants). Placement of a tissue expander at the time of original surgery indicates that reconstruction is planned as part of the first course of treatment. Assign code 51 or 52 if a patient has an excisional biopsy and axillary dissection followed by a simple mastectomy during the first course of therapy.]

60 Radical mastectomy, NOS
- 61 WITHOUT removal of uninvolved contralateral breast
  - 64 Reconstruction, NOS
  - 65 Tissue
  - 66 Implant
  - 67 Combined (Tissue and Implant)

62 WITH removal of uninvolved contralateral breast
- 68 Reconstruction, NOS
- 69 Tissue
- 73 Implant
- 74 Combined (Tissue and Implant)

[**SEER Notes**: Removal of breast tissue, nipple, areolar complex, variable amount of skin, pectoralis minor, pectoralis major. Includes en bloc axillary dissection. Placement of a tissue expander at the time of original surgery indicates that reconstruction is planned as part of the first course of treatment.]

70 Extended radical mastectomy
- 71 WITHOUT removal of uninvolved contralateral breast
- 72 WITH removal of uninvolved contralateral breast

[**SEER Note**: Removal of breast tissue, nipple, areolar complex, variable amount of skin, pectoralis minor, pectoralis major. Includes removal of internal mammary nodes and en bloc axillary dissection.]

80 Mastectomy, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY